Methods and Standards for Establishing Payment Rates: Other Types of Care

Advanced Nurse Practitioners (Family and Pediatric)

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. Drugs are reimbursed at 95% of the AWP without a dispensing fee.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitation services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavior Rehabilitation Services rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards.

Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge.

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge.

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Family Planning Services and Supplies

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures without an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule.

Federally Qualified Health Center Services

Federally-Qualified Health Centers will be reimbursed for Medicaid covered services at 100 percent of their reasonable costs. All-inclusive interim rates are established, and, after the end of the facility's fiscal year, are reconciled with the results of an audit of the facility's cost reports.

Home and Community-Based Waiver Services

A unit of care coordination service is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized equipment and supplies is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized private duty nursing service is reimbursed at the lesser of the amount billed the general public or the following state maximum allowable: registered nurse, $25 per hour; advanced nurse practitioner, $25; licensed practical nurse, $20 per hour.

A unit of environmental modifications service is reimbursed at 100 percent of billed charges up to a maximum of $10,000 per 36-month waiver period, plus an administrative fee for certain providers as approved by the managing state agency. Services must be prior authorized.

The managing state agency will determine for each provider the amount of reimbursement for a unit of adult day care, chore, habilitation, meals, respite, or waiver transportation service based on the allowable direct service costs for the service provided, plus an allowance to compensate the provider for the allowable administrative and general costs associated with providing the service.

Reimbursement for a unit of residential supported living service is determined by the managing state agency based on a daily unit of service. Rates are negotiated on a per recipient per provider per waiver year basis.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Home Health Services

Payment is made at 80 percent of billed charges.

Hospice Care Services

Payment is at the Medicaid rates published annually by the Health Care Financing Administration.

Laboratory Services

Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge.

Medical Supplies and Prosthetic Devices

Payment for durable medical equipment and supplies and prosthetic devices is made at lesser of amount billed the general public or the state maximum allowable. Payment for unusual or custom equipment is authorized on a case-by-case basis and may not exceed the authorized amount.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Mental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a psychiatrist) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Mental Health and Developmental Disabilities under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally-ill persons seeking admission to or residing in long-term care facilities. The State assures that the requirements of 42 CFR 447.325 regarding upper limits of payment will be met.

Mental Health Rehabilitation Services

The following mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

(a) crisis intervention;
(b) family, group and individual therapy;
(c) psychological testing and evaluation;
(d) medication management;
(e) intake and psychiatric assessments;
(f) home-based therapy;
(g) activity therapy;
(h) day treatment;
(i) intensive rehabilitation;
(j) psycho-social rehabilitation; and
(k) family and client support services.
(l) medication administration services

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Nutrition Services

Payment to a registered dietitian is limited to the lesser of the amount billed the general public or $50 for the first 30 minutes of an initial assessment, $25 for each additional 15 minutes of the initial assessment, and $17.50 for each 15 minutes of services following the assessment.

Outpatient Hospital Services

For all Alaska hospitals, except those electing to be reimbursed under the Optional Rate Methodology for Small Facilities, the method of establishing payment for outpatient hospital services is the same as for inpatient hospital services under Attachment 4.19A. Alaska hospitals electing to be reimbursed under the Optional Payment Rate Methodology for Small Facilities are reimbursed a percentage of charges calculated as the overall Medicaid cost-to-charge ratio for allowable ancillary departments in the rate base, not to exceed 100 percent of charges. The rate base is the facility's approved inpatient hospital Medicaid rate and the department's rate analysis for the facility's fiscal year that began during the period January 1, 1997 to December 31, 1997.

Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Physician Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure code billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are those published in the Federal Register, Volume 60, Number 236, dated December 8, 1995. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Payment for the services of a physician collaborator is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU for a physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, audiologist, speech language pathologist, or certified registered nurse anesthetist. Payment for the services of a physician collaborator who is a community health aide III or IV or a community health practitioner certified by the state is made in the same manner as other physician collaborators except that physician reimbursement for a community health aide III or IV is limited to 20 percent of the Resource Based Relative Value Scale methodology, and for a community health practitioner is limited to 30 percent of the Resource Based Relative Value Scale methodology.

Surgical reimbursement is in accordance with the Resource Based Relative Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent of the RBRVS rate for the highest procedure and 50 percent of the RBRVS rate for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting payment between the surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule. Prescription drugs dispensed by a physician are reimbursed at 95% of the Average Wholesale Price (AWP) without a dispensing fee.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Payment is made to independently enrolled hospital-based physician for certain services at the lessor of the amount billed the general public or 46.92 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using base units and time units and a state determined conversion factor.

Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU.

Prescribed Drugs

(a) Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and are not directly reimbursed.

(b) The payment for multiple source drugs for which the Health Care Financing Administration has established a specific upper limit amount will be the lesser of the amount billed or that upper limit, plus the dispensing fee.

(c) The payment for drugs other than those of (b) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.331 will be the dispensing fee plus the estimated acquisition cost of that drug, which is the average wholesale price published in the American Druggist Blue Book, as updated monthly, less 5 percent of that amount. However, the payment will not exceed the lower of the estimated acquisition cost plus the dispensing fee, or the provider's lowest charge.

(d) The payment for compounding prescriptions will be the sum of the costs of each of the ingredients as established under (b) or (C) (above), plus the dispensing fee, plus an additional compounding rate of $5.75 for each 15 minutes required to compound the prescription.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Prescribed Drugs (continued)

(e) The dispensing fee is based on the result of surveys of Alaska pharmacies' cost of dispensing prescriptions. For each pharmacy, the dispensing fee will be determined using the following formula: $23,192 is added to the result of multiplying the annual number of prescriptions by 5.070. To this number is added the result of multiplying the annual number of Medicaid prescriptions by 12.44. From this number is subtracted the result of multiplying the total store volume expressed in square feet by 2.103. The resulting number is then divided by the total annual number of prescriptions. To the result of this division is added $0.73. However, the division will not pay a dispensing fee less than $3.45 or more than the 90th percentile of all fees determined under the formula. New pharmacies which do not have the information available to establish a fee will be assigned the statewide average fee until a year of data is available.

(f) If a pharmacy does not provide dispensing fee data as requested by the division, the division will either pay that pharmacy the minimum dispensing fee established under (e) above or sanction the pharmacy.

(g) Payments made to dispensing providers will be for the estimated acquisition costs and will not include a dispensing fee. Dispensing providers include physicians, advanced nurse practitioners, rural health clincs, federally qualified health centers, and Indian Health Service and tribal health facilities.

(h) Payments to providers outside of Alaska will be made at the Medicaid rate of their state. For Canadian providers, payments will be the lesser of the normal charge to the typical walk-in, cash-paying customer or the lowest total payment made for the same drug to a provider in Alaska.

(i) A special state-established fee will be allowed for unit-dose dispensing of drugs to recipients in long-term care facilities.

(j) A special state-established dispensing fee and a special state established compounding fee will be allowed for preparing drugs in a sterile environment.

(k) Payment is restricted to drugs supplied by manufacturers who have a signed national agreement or an approved existing agreement under the Medicaid Drug Rebate program of Sec. 1902(a)(54) and Sec. 1927 of the Act, and the only drugs supplied by such manufacturers that are not reimbursed are those excluded under Attached Sheet to Attachment 3.1A.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Private Duty Nursing for Children Under 21

Payment for private nursing is the lesser of amount billed the general public or $80 per hour for registered nurse services and $75 per hour for licensed practical nurse services. Hours must be justified in a physician-approved plan of care, must be less than 24 hours per day, and cannot, when added to the other Medicaid services used by the child, exceed the cost of institutional care.

Radiology Services

Payment for radiology services provided by independent radiology facilities is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. The state assures that the requirement of 42 CFR 447.325 regarding upper limits of payment will be met.

Residential Treatment for Children Under 21

Payment to a non-profit facility accredited by JCAHO for residential treatment of emotionally disturbed children is an all-inclusive daily rate established by the department.

Respiratory Therapy Services

Payment for respiratory therapy services is made at the lesser of the amount billed the general public or the state maximum allowable.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Rural Health Clinic Services

(a) For services covered under Medicare Part B, payment is for the deductible and coinsurance.

(b) For services not covered under Medicare that are covered under this State plan, payment to provider-based clinics is made according to the Medicare fee schedule.

(c) For clinics other than provider clinics, payment is made according to the Medicare fee schedule, as required under 42 CFR Part 405 Subpart X.

The state assures that the requirements of 42 CFR 447.371 regarding upper limits of payment will be met.

Speech, Hearing and Language Services

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment for hearing services provided by an audiologist is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable.

Substance Abuse Rehabilitation Services

The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

(a) assessment and diagnosis services;
(b) outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
(c) intensive outpatient services;